STATE OF NEW HAMPSHIRE
BOARD OF MEDICINE
2 Industrial Park Dr. #8
Concord, NH 03301

CONSUMER COMPLAINT FORM
l-800-780-4757

Please type or print clearly Please provide all reauested information

NAME OF PHYSICIAN: _____ **OFFICE PHONE:** _____

ADDRESS: _____

NAME OF CLINIC OR HOSPITAL (IF APPLICABLE): _____

NAME OF PERSON REGISTERING COMPLAINT: _____ **RELATIONSHIP TO PATIENT:**

ADDRESS: _____ _____

HOME PHONE: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **WORK PHONE:** _____

Has the patient consulted any other physician regarding this same complaint?
If so, please give the name and address: _____

DETAILS OF COMPLAINT

TYPE OF ILLNESS/REASON FOR VISIT: _____ **DATE:** _____

WHAT ARE YOUR SPECIFIC CONCERNS? _____

Attach additional sheets as necessary

NOTICE: Please provide as much detailed, factual information as possible. The information on this form will be used in part to determine whether a violation of state law has occurred. If a violation is substantiated, the information may be transmitted to the licensee or to other government agencies which assist in disciplinary investigations, including the Attorney General's Office.

SIGNATURE: _____ **DATE:** _____